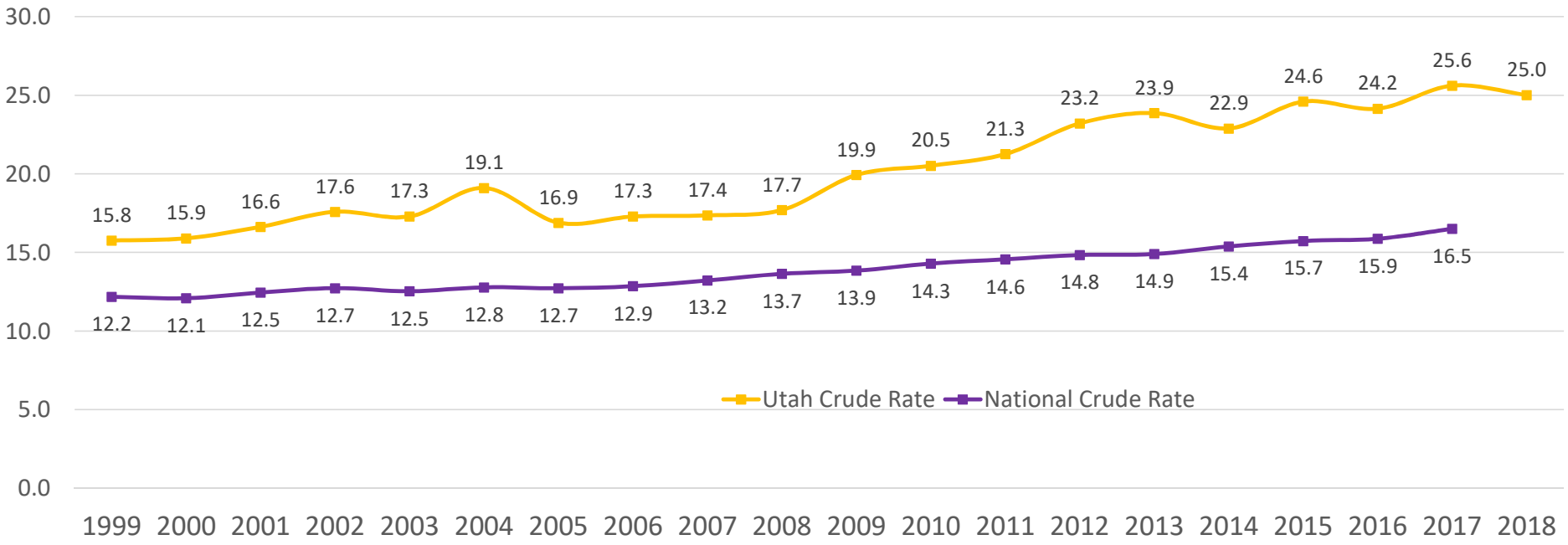
Suicide Screening and Risk Assessment

Disaster Crisis Counseling Certification/Re-Certification Workshop

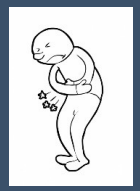
Agenda

- Links between traumatic experiences and suicide risk
- Screening: Tools and Considerations
- Assessment: Tools and Considerations
- Introduction of Brief Interventions to Mitigate Risk
- Resources

Suicide in Utah and U.S.



Trauma Can Manifest Many Ways



PHYSICALLY

COGNITIVELY & EMOTIONALLY

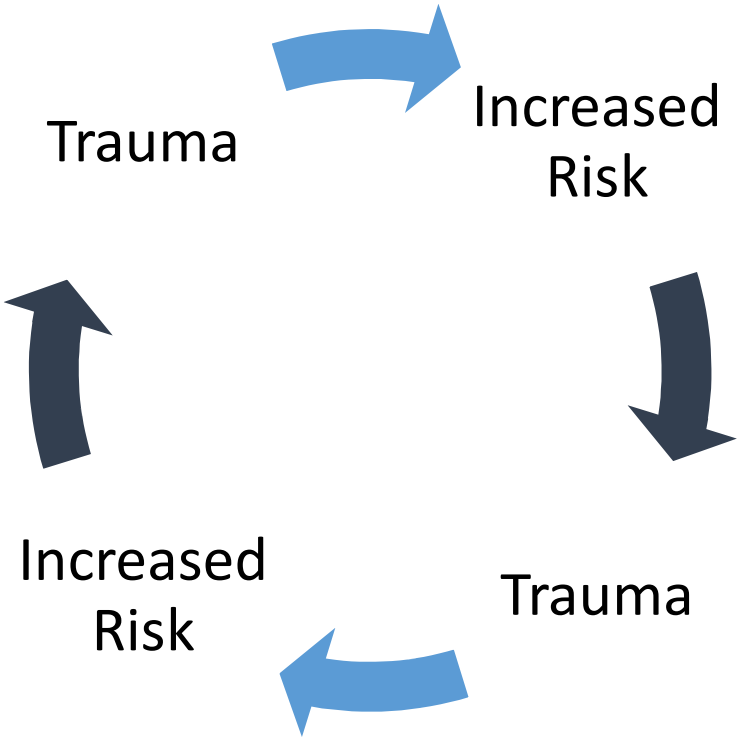
BEHAVIORALLY

utah department of human services

Common Reactions to Trauma

- Anxiety and fear
- Re-experiencing of the trauma
- Increased vigilance
- Avoidance
- Anger
- Guilt and shame
- Grief and depression
- Negative self and world view
- Relationship challenges
- Increased use of alcohol/drugs

Trauma Exposure and Suicide Risk: Problematic Cycle



Suicide Risk and Disasters

- Suicide rates increased in the four years after floods by 13.%

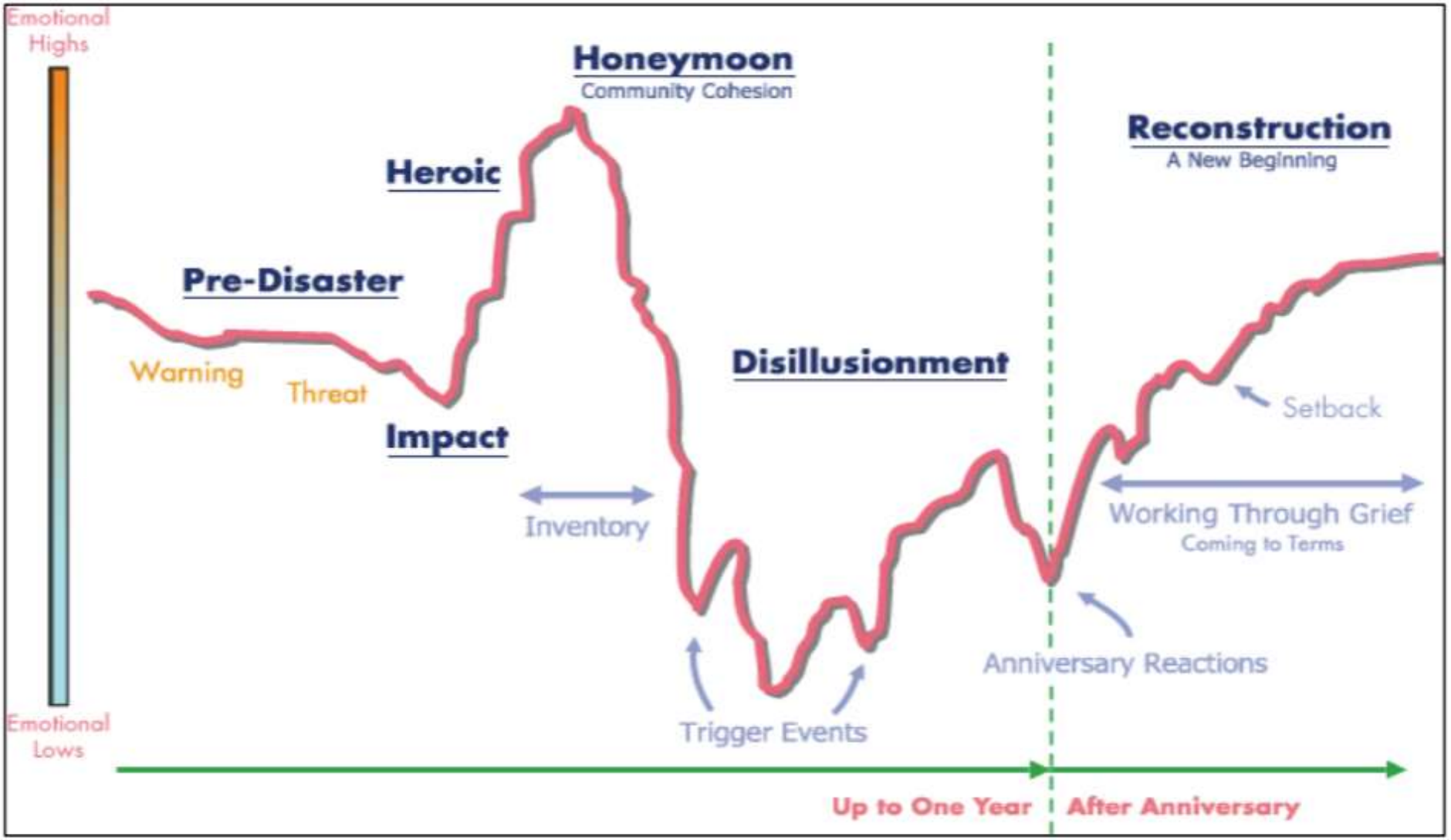
- Suicide rates increased in the two years after hurricanes by 31.0%

- Suicide rates increased in the first year after earthquakes by 62.9%

Suicide Risk and Disasters

- Slight decrease in suicide risk in New York City after 9/11 terrorist attacks

- For three years after the Northridge earthquake suicide rates dropped significantly in Los Angeles



Adapted from Zunin & Myers as cited in DeWolfe, 2000.

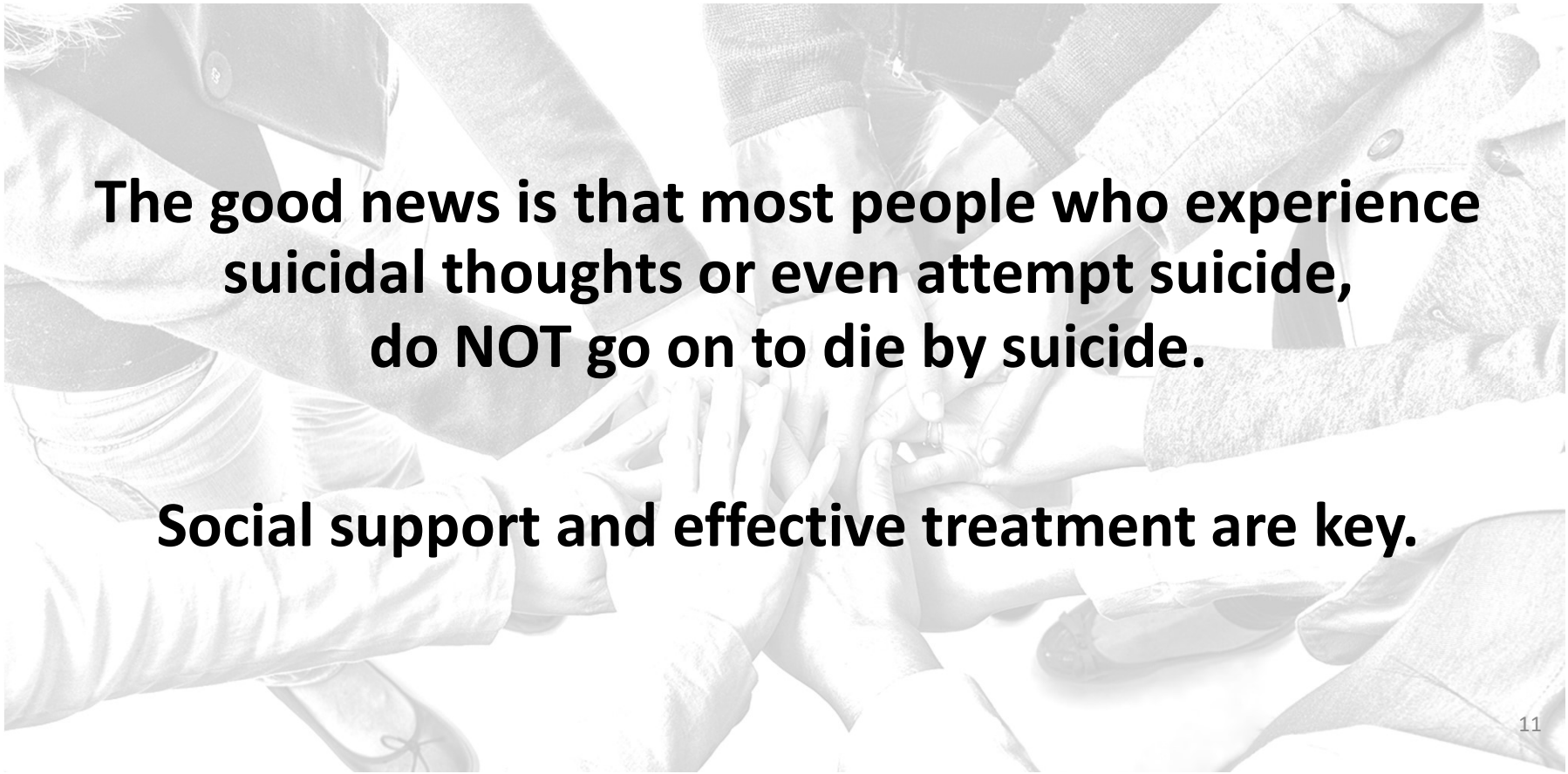
Understanding Suicide

In general, if a person is suicidal it does not actually mean they want to die. It simply means they want to end unbearable physical or emotional pain, or find a solution to an inescapable problem.

Because of this, most people experience intense uncertainty about suicide. A part of the person may still be hopeful or connected to people, pets, or purpose in life.

We can help them reconnect to those reasons for living.

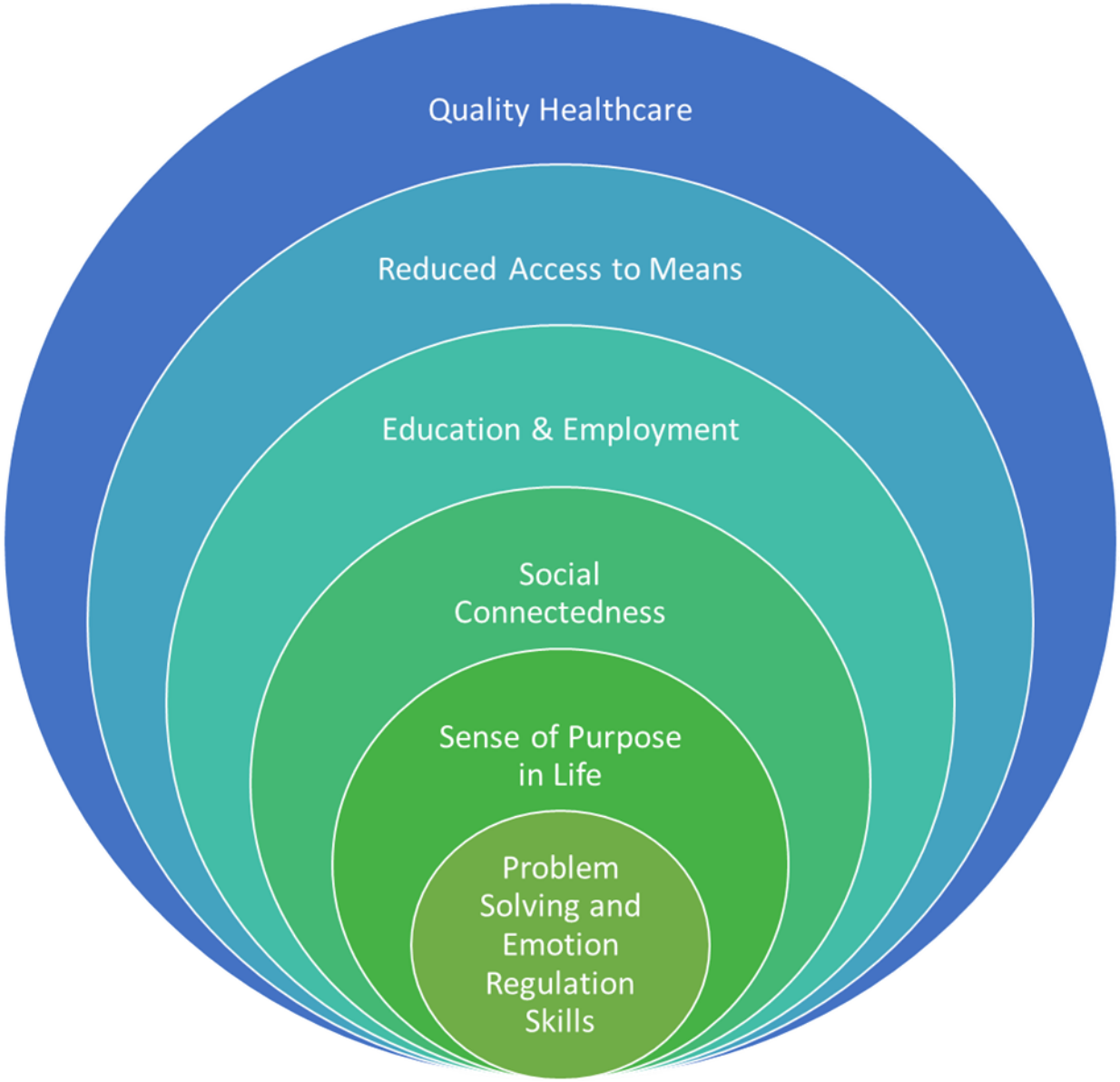
Understanding Suicide



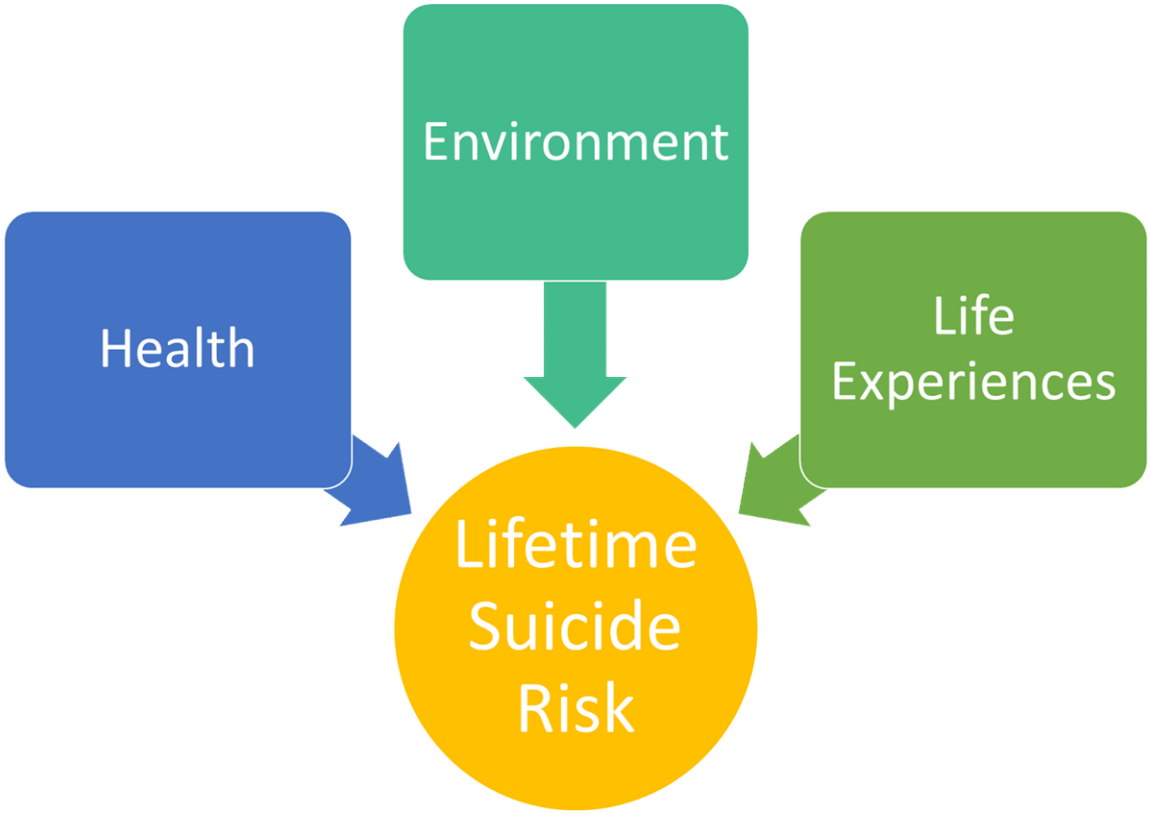
The good news is that most people who experience suicidal thoughts or even attempt suicide, do NOT go on to die by suicide.

Social support and effective treatment are key.

Circles of Suicide Protection



Contributors to Suicide Risk



Warning Signs For Immediate Risk

Said Out Loud

- "My family would be better off without me"
- "I just make things worse for everyone"
- "I just can't take it anymore"
- "What's the point? It will never get better"
- "I wish I could go to sleep and never wake up"
- "You don't need to worry about me anymore"
- "If _____ happens, I'll kill myself."

Observed

- Behaving recklessly- drunk driving, excessive spending
- Saying goodbyes or tying up loose ends
- Increasing alcohol or drug use
- Sleeping too little or too much
- Withdrawing
- Sudden unexplained calm or uplifted mood
- Giving away pets or possessions
- Seeking or researching methods of suicide

How to Ask Directly About Suicide

- Ask directly, in a manner that shows that suicidal thoughts are understandable in their circumstances.
- *“Sometimes people (in your situation) feel like they don’t want to live anymore, or sometimes they think about killing themselves. Have you been having any thoughts like these?”*
- *“You said that you are feeling like you ‘can’t handle it anymore’. When you say that, do you mean you are thinking about suicide?”*
- *“With all of the stress and painful emotions you are describing to me, it would be understandable if you have had thoughts of ending your life. Have you had any thoughts like that?”*

Screening for Suicide

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS:	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan." ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it…and I would never go through with it.*" ***Have you been thinking about how you might kill yourself?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question ***"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***How long ago did you do any of these?*** • Over a year ago? • Between three months and a year ago? • Within the last three months?		

Suicide Prevention depends upon appropriate identification and screening

CSSRS

- Shared language
- Catches things that may be missed with other tools
- Can rely on multiple sources to gather information
- Only need to prompt until all relevant information gathered
- Provides tool for documentation and liability- can clearly show why we did what we did
- Screening Version 3-6 questions

Find training at
http://zerosuicide.actionallianceforsuicideprevention.org/

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Considerations on Screening: Overreliance on Self Disclosure

- Ask about suicide ideation (SI)
  - If SI is present, peel the onion

- Continue the suicide risk assessment even if SI is declined, based on assessment of chronic risk factors (vulnerability to be suicidal) and acute risk factors (associated with near-term risk)

- Suicide risk may still be high and acute even if current SI is denied

(Berman, in preparation)

Reasons for Denial of Suicide Ideation

- Not thinking of suicide at that moment
- Unclear wording of question
- Poor comprehension of question
- Feared loss of autonomy, loss of functional relationship, loss of employment
- Feared negative judgment/stigmatization
- Belief can't be helped
- Belief = sign of weakness

(Berman, in preparation)

Factors to Consider for Screening/Assessment

Common with denial of Suicidal Ideation	Denied
Social Isolation/Withdrawl	58%
Angry Irritability	47%
Anxiety/Agitation	78%
Sleep Disturbance	76%
HX SI/SA	82%
IPP/Job or Money Strains	73%
Hopelessness/Catastrophic Thinking	73%

(Berman, in preparation)

What do I say when the answer is yes?

- “Thank you for being honest, I know this can be hard to talk about.”
- “I’m glad you told me. I think I might be able to help.”
- “It sounds like you are in a lot of pain, I’m sorry you are going through this.”

Listening

How can it be powerful to take time to listen?

- It helps the person feel cared for
- It can help the person gain insight into their own thoughts
- It can give you clues of social supports, past coping or help seeking efforts, past suicide attempts, or current suicide planning

Listening

You may want to ask open ended questions, such as:

- How long have you been feeling this way?
- Will you tell me the story of how you got to this point?
- Can you tell me about the day you felt most suicidal- what was happening? What did you do to cope?

Give them time to talk without jumping to advice or problem solving.

Allow yourself time to take a breath and stay present with the person.

The purpose of the assessment is not to *predict* suicide but rather to *plan* effective suicide care.

Basic Risk Assessment

Ask about planning, means, and past suicide behaviors.

Have you thought about how you would end your life?

Do you have a plan for how you will end your life?

Do you have the items you would use to end your life?

How likely are you to carry out this plan?

Have you ever tried to kill yourself before?

Core Risk and Protective Factors to Address

- Psychiatric Disorders
- Suicidal Behaviors (including preparatory)
- Key Symptoms (eg Hopelessness)
- Family History
- Precipitating Events and Stressors
- Interpersonal Relationships
- Changes in treatment
- Access to firearms

- Ability to cope/skills to cope
- Beliefs against suicide
- Frustration tolerance
- Sense of responsibility to something else (eg children, pets, etc…)
- Positive therapeutic relationships
- Social supports

Narrative Assessment

Ask patient to describe the chronology of events for the suicidal episode that led up to the crisis

- “Let’s talk about your suicide attempt/what’s been going on lately.”
- “Can you tell me the story of what happened?”

Assess events, thoughts, emotions, physical sensations, and behaviors

- “What happened next?”
- “And then what happened?”
- “What were you saying to yourself at that point?”
- “Did you notice any sensations in your body at that point?”

Risk Assessment

Previous suicide attempts

- Emphasis on intent:
  - "What did you hope would happen?"
  - "Did you want to die?"
  - "Were you happy to be alive, or did you wish you were dead afterwards?"
- Patterns: first, worst, most recent
- Worst-point suicidal episode

Bryan & Rudd (2006)

Risk Assessment

Precipitant / triggering event

- Almost always some sort of perceived loss

Symptomatic presentation

- Mood
- Hopelessness
- Perceived burdensomeness
- Thwarted belongingness
- Agitation
- Insomnia

Bryan & Rudd (2006)

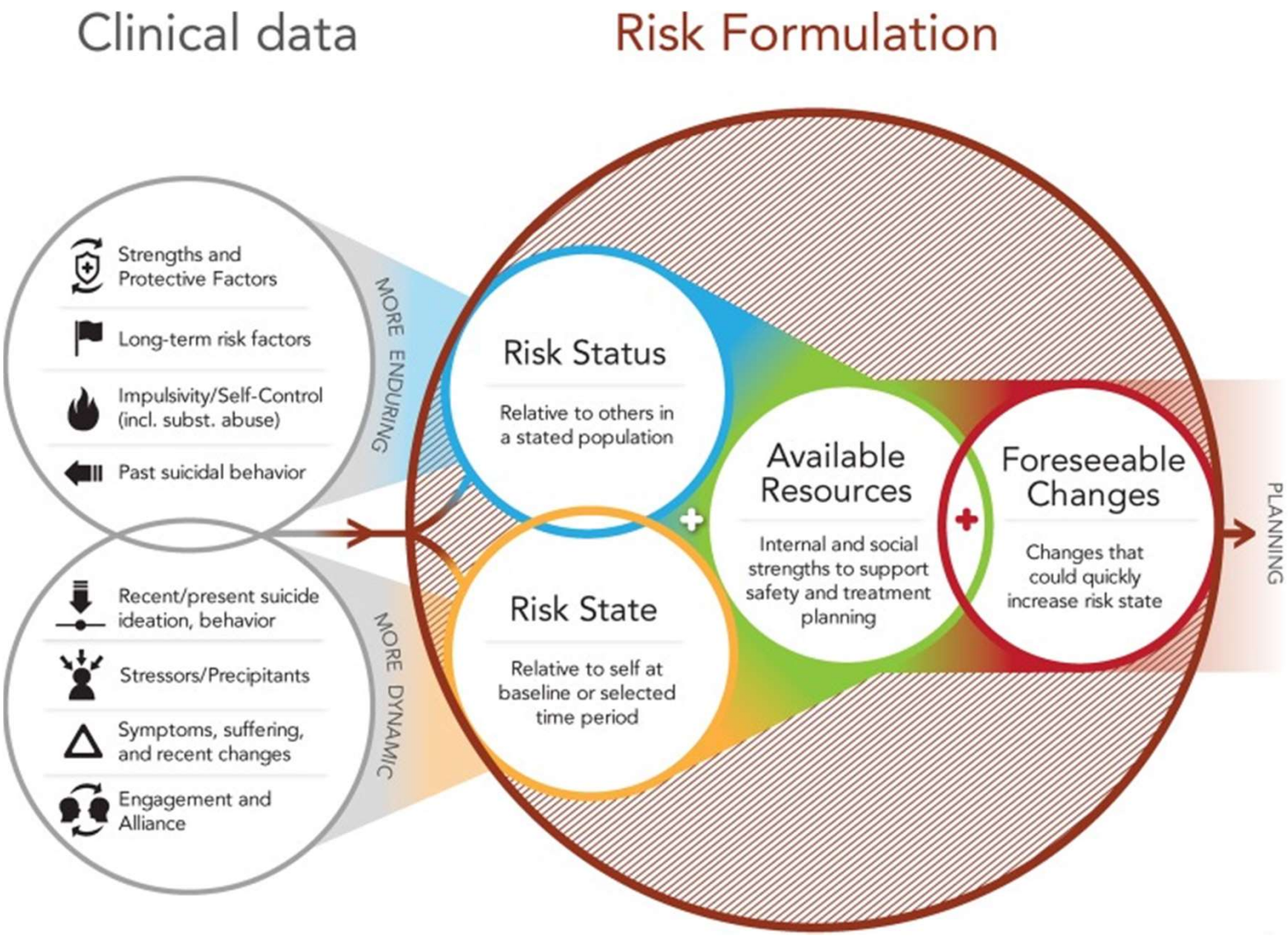
Risk assessment

Nature of suicidal thinking

- Suicidal intent: subjective vs. objective

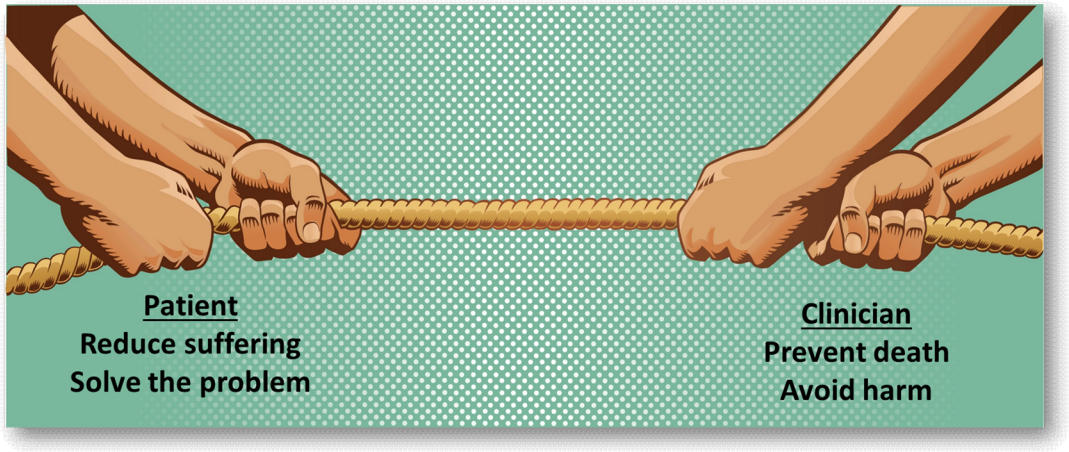
Objective	Subjective
▫ Isolation	▫ Self-report of desired outcome
▫ Likelihood of intervention	▫ Expectation of outcome
▫ Preparation for attempt	▫ Wish for death
▫ Planning	▫ Low desire for life
▫ Writing a suicide note	

Bryan & Rudd (2006)


Clinical data
Risk Formulation
Strengths and Protective Factors
Long-term risk factors
Impulsivity/Self-Control (incl. subst. abuse)
Past suicidal behavior
MORE ENDURING
Recent/present suicide ideation, behavior
Stressors/Precipitants
Symptoms, suffering, and recent changes
Engagement and Alliance
MORE DYNAMIC
Risk Status
Relative to others in a stated population
Risk State
Relative to self at baseline or selected time period
Available Resources
Internal and social strengths to support safety and treatment planning
Foreseeable Changes
Changes that could quickly increase risk state
PLANNING

Responding to Identified Risk

- Creating treatment plan to include:
  - Addressing both short-term crisis and long-term vulnerability
  - Specific crisis intervention
  - Arranging appropriate follow-up and next steps
  - Continue to evaluate ongoing
- Work to align clinician and patient goals



Brief Interventions

Goal of brief interventions:

- Prevent suicidal behaviors
- Increase suicide related coping skills
- Decrease ideation
- Enhance treatment engagement

Why use brief interventions?

- OP treatment not for everyone
- Problems with treatment engagement and retention
- Evidence and broad ability to use suicide specific treatment modalities.
- Accessible and low cost

Theoretical Approach to Brief Interventions

- Suicide risk is episodic and can fluctuate over time
- Problem solving capacity decreases during times of crisis. Over practice and specific template enhances coping
- Safety Planning Intervention (SPI) comes from cognitive behavioral approaches
- Consider one aspect of suicide prevention- not the only aspect

Introduction to Safety Planning

A Safety Plan is a brief intervention that can significantly reduce suicide attempts.

Compared to a contract for safety, those receiving a crisis response plan had a 76% reduction in suicide attempts at 6 month follow up. Crisis response planning was associated with significantly faster decline in suicide ideation ($F(3,195)=18.64$, $p<0.001$) and fewer inpatient hospitalization days ($F(1,82)=7.41$, $p<0.001$).

Bryan, Craig J et al. Effect of crisis response planning vs. contracts for safety on suicide risk in U.S. Army Soldiers: A randomized clinical trial. 2017. Journal of Affective Disorders , Volume 212 , 64 - 72.

Introduction to Safety Planning

- Rather than telling the person what NOT to do (act on their suicidal thoughts), a safety plan helps the person know what they CAN do to feel better and stay safe.

Elements of a Safety Plan

1. Three warning signs that a crisis may be developing (including thoughts, mood, situation, behavior)
2. Three Internal coping strategies- Things I can do to take my mind off my problems without contacting another person (i.e. relaxation techniques, exercise, uplifting music)
3. Four people and social settings that provide distraction (list names & places)
4. Three people I can ask for help and their phone numbers
5. Three to four professionals/agencies I can contact during a crisis (including clinician, SafeUT app, and Suicide Prevention Lifeline 1-800-273-TALK, emergency room, 911)
6. Reasons for living
7. Strategies to make the environment safe

Counseling on Access to Lethal Means

Referral Resources

1. **Suicide Prevention Lifeline 1-800-273-TALK (8255)**
    1. **MCOT in urban counties**
2. **SafeUT App**
3. Trevor Project Lifeline 1-866-488-7386 (24/7/365); text or chat online (7 days a week between 1 and 8 pm Mountain Time) 1-202-304-1200
4. 211
5. Local Mental Health Authority https://dsamh.utah.gov/mental-health/
6. NAMI Utah https://www.namiut.org/
7. American Foundation for Suicide Prevention https://afsp.org/

Thank you!

Kim Myers

Suicide Prevention and Crisis Services Administrator

kmyers@Utah.gov